

12040

# CERTIFICATE OF DEATH

Reg. Dist. No. 190

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Howard</b>	<b>MARYLAND</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	COUNTY <b>Howard</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>	COUNTY <b>Howard</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Montgomery and Lawyer Hill Roads</b>		STREET ADDRESS (If rural, give location) <b>Montgomery and Lawyer Hill Roads</b>	
3. NAME OF DECEASED (Type or Print) <b>ANNIE FRANCES ATWELL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 9, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Oct. 16, 1869</b>
9. AGE last birthday <b>86</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Richard H. Hagner</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hungerford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT & ADDRESS <b>Mrs. Meriam Hanna, Elkridge, Md.</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <b>Acute coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chr Myocarditis</b>		5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>General arteriosclerosis</b>		11	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Senility</b>		10 yrs	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 1950, to Dec. 9, 1955, that I last saw the deceased alive on Dec. 5, 1955, and that death occurred at 6 A.M. from the causes and on the date stated above.			
SIGNATURE <b>E. Bied Wilkins</b>		ADDRESS (Street, city, town, state) <b>1609 main St Elkridge 27 Md</b>	
M.D. <b>E. Bied Wilkins</b>		DATE SIGNED <b>Dec 12 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Dec. 12, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>Grace Episcopal</b>	LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <b>E. Bied Wilkins</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Higinbotham</b>	ADDRESS <b>Ellicott City, Md.</b>
DATE <b>Dec. 12, 1955</b>			

# CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTRY

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

BUREAU W. 3

DEC 13 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12033

12041

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town.) OR TOWN <u>Ellicott City</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town.) OR TOWN <u>Ellicott City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood</u>				STREET ADDRESS (If rural give location) <u>Homewood</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ROBERT CAMPBELL BAKER</u>				<b>4. DATE OF DEATH</b> (Month) <u>Dec.</u> (Day) <u>1</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 18, 1903</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant on Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Baker</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-5173</u>		17. INFORMANT & ADDRESS <u>Gerald R. Baker, Ellicott City, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
180X IMMEDIATE CAUSE (A) <u>Cachexia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypernephroma, left kidney with metastases to</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>left lung, liver, and brain.</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 6</u> , 19 <u>55</u> , to <u>Dec 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 1</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles S. Whitaker,</u>				ADDRESS (Street, city, town, state) <u>Clarksville, Maryland</u>		DATE SIGNED <u>Dec. 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-4-55</u>		NAME OF CEMETERY OR CREMATORY <u>Liberty Baptist</u>		LOCATION (City, town, or county) (State) <u>Lisbon, Md</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 4, 1955</u>		REGISTRAR'S SIGNATURE <u>Marie A. Whitaker</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md.</u>		ADDRESS	

# CERTIFICATE OF DEATH

Reg. Dist. No.

IN CASE OF DEATH OF PERSON

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
MARRIED  
OCCUPATION

MARYLAND  
COUNTY OF  
CITY OF

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH

EDUCATION  
RELIGION  
MARRIAGE  
PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

PREVIOUS MEDICATION  
PREVIOUS TREATMENT  
PREVIOUS DIAGNOSIS  
PREVIOUS PROGNOSIS  
PREVIOUS OUTCOME  
PREVIOUS FOLLOW-UP  
PREVIOUS REFERENCE

BUREAU V. S.

DEC 7 1955

RECEIVED

RECEIVED

12042

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

## 1. PLACE OF DEATH:

COUNTY **Howard** MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Ellicott City** LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **Holland Manor Nursing Home**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Baltimore**  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Baltimore**  
 STREET ADDRESS **2100 E. Pratt St.** (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**Francesca****Lantieri Balsamo**

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

**Dec. 2 1955**

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

**Female****White****Married****Jan. 19 1886****69****yrs.****Months****Days****Hours****Min.**

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

**Tailor**

## 10b. KIND OF BUSINESS OR INDUSTRY:

**Tailor Shop**

## 11. BIRTHPLACE (State or foreign country):

**Valguarnera Italy**

## 12. CITIZEN OF WHAT COUNTRY?

**Italy**

## 13. FATHER'S NAME:

**Giuseppe Forte**

## 14. MOTHER'S MAIDEN NAME:

**Maria Gangi**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

**213-03-4944**

## 17. INFORMANT &amp; ADDRESS:

**Pasquale Balsamo 2100 E. Pratt St.**

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**Immediate cause**

(a)

DUE TO

**Antecedent causes (s)****Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.**

(b)

DUE TO

(c)

**Carcinoma of Cervix of Uterus**

Interval Between Onset And Death

**3 yrs.**

## 11. OTHER SIGNIFICANT CONDITIONS

**Conditions contributing to the death but not related to the disease or condition causing death.****Memorial, probably 20% obstruction of both ureters chronic pyelonephritis**

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/15, 1955, to 12/2, 1955, that I last saw the deceased

alive on 12/1, 1955, and that death occurred at 5226 Balt Nat. Pike, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REINTERMENT (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

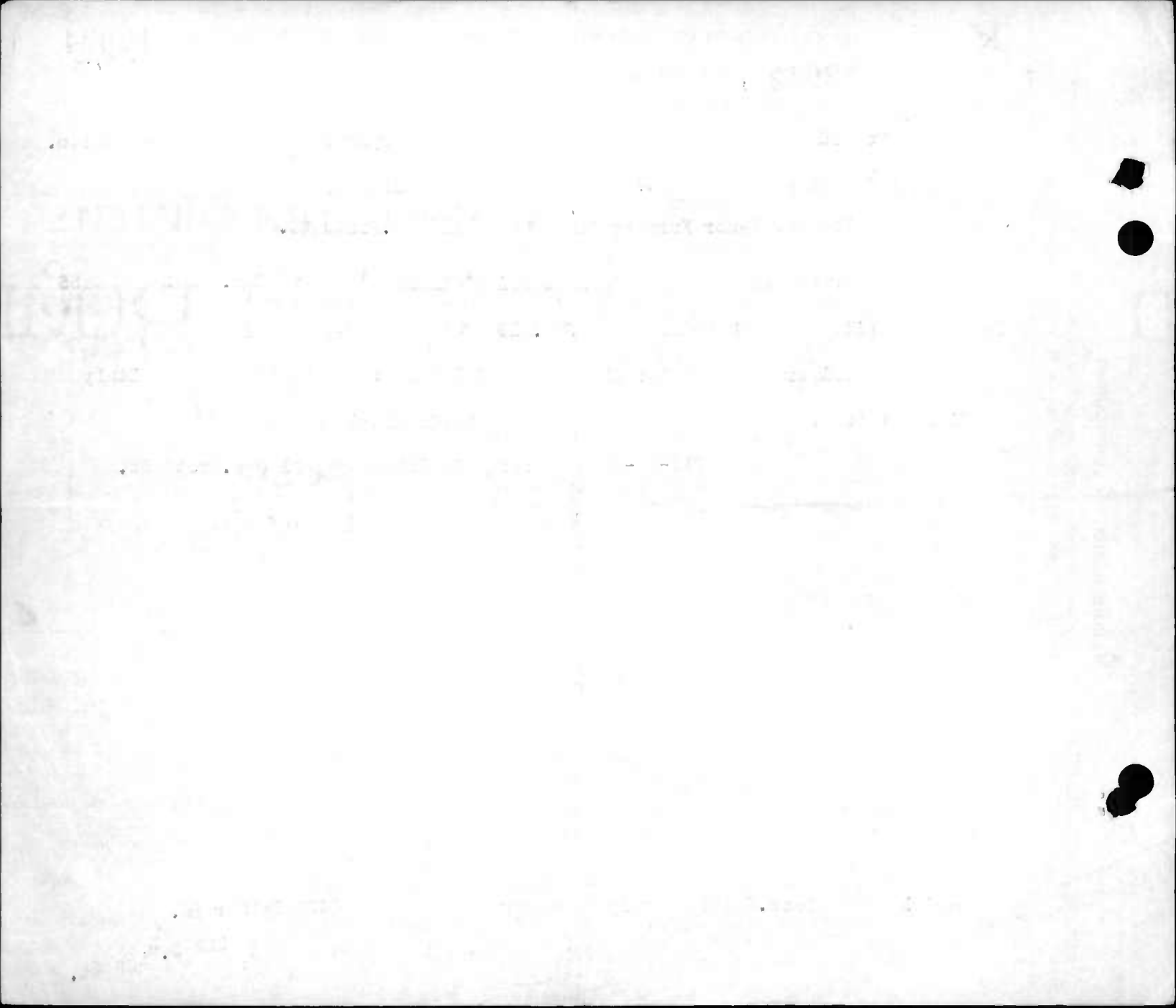
FUNERAL DIRECTOR

ADDRESS

**12-5-55****J. W. Federal****Frank Deller****322 S. High St.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12035

## 12043 CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Woodstock</u>				TOWN <u>Woodstock</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u> (Middle) <u>AUGUSTUS</u> (Last) <u>BIDINGER</u>				(Month) <u>Dec.</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 28, 1879</u>	<u>76</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Railroad Section Hand</u>		<u>Lisbon, Md</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ellwood Bidinger</u>				<u>Sarah Hobbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>?</u>		<u>Mary Bidinger, Woodstock, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
571.1 IMMEDIATE CAUSE (A) <u>Cerebrum &amp; Malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Colitis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1950, to 12/13/1955, that I last saw the deceased alive on 12/12/1955, and that death occurred at 12:55 P.M. from the causes and on the date stated above.							
SIGNATURE <u>John E. Martine</u>				ADDRESS (Street, city, town, state) <u>Pandalltown, Md.</u>			
DATE <u>12-6-55</u>				DATE SIGNED <u>12/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>12-6-55</u>		<u>Granite Methodist</u>		<u>Granite Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Oliver A. H. et al.</u>		<u>F.C. Higinbotham, Ellicott City, Md.</u>			

ENCLOSURE

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED WAS A RESIDENT OF THE DISTRICT OF COLUMBIA AT THE TIME OF HIS DEATH AND THAT HE WAS A NATURAL BORN CITIZEN OF THE UNITED STATES OF AMERICA.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

DEC 14 1955

RECEIVED



12044

## CERTIFICATE OF DEATH

Item 8, Film G191 1-11-56 et

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Howard MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Jessups  
 TOWN Jessups  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Guilford Rd

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Howard  
 CITY (If outside corporate limits, write RURAL and give nearest town) Jessups  
 OR TOWN Jessups  
 STREET ADDRESS (If rural give location) Guilford Rd

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 4. DATE OF DEATH:

(Month)

(Day)

(Year) 1956

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset and Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

## INJURY OCCURRED

While at Work ☐Not While At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 9/21, 1955, to 12/27, 1955, that I last saw the deceasedalive on 12/27, 1955, and that death occurred at 11:00 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8131

12045

12037

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Westminister</u> <u>06-27-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor's Manor Hospital</u>				STREET ADDRESS (If rural, give location) <u>75 W. Main St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>DOLORES S GEIMAN</u>				<u>Dec. 24 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Nov. 12, 1919</u>	
9. AGE last birthday: <u>36</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Buldean, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Calvin Street</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>J. Stoner Geiman Jr. Westminister, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>974X</u> Immediate cause (a) <u>Strangulation by hanging</u> DUE TO Antecedent cause(s) (b) <u>Obsessive Compulsive reaction with Depression.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>15 Min.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Obsessive Compulsive reaction with Depression.</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Sanitorium</u>		21c. (City or town) (County) (State)		20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>Ellicott City</u>		<u>Howard</u>		<u>Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 24, 1955 6.20 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hung Self from Door Jam of room</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>George E. Bunting</u>		Ellicott City, Md		M. D. CHIEF MEDICAL EXAMINER <u>12-24-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12. 28. 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Westminister Cem.</u>		LOCATION (City, town, or county) (State) <u>Buldean N.C.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 34, 1955</u>		REGISTRAR'S SIGNATURE <u>John B. Loughran, Jr.</u>		24. FUNERAL DIRECTOR <u>W. Bankard</u>		ADDRESS <u>Westminister, Md.</u>	
		<u>B. E. L.</u>					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

1

## 12046 CERTIFICATE OF DEATH

Reg. Dist. No. 191

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ellicott City</u>				TOWN <u>Ellicott City</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>23 Fells Ave.</u>				STREET ADDRESS (If rural give location) <u>23 Fells Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>CHARLES</u> (Middle) <u>LOUIS</u> (Last) <u>POOLE</u>				Dec. 24, 1955 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	Widower	1887	68 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		None		North Carolina			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Poole				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		220-20-6412		Charles E. Poole, Ellicott City, Md			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						1 HR.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ATHEROSCLEROSIS</u>						YEARS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>DEC 24</u> , 19 <u>55</u> , <b>to</b> <u>DEC 24</u> , 19 <u>55</u> , <b>that I last saw the deceased alive on</b> <u>DEC 24</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>7:50 P.M.</u> <b>from the causes and on the date stated above.</b>							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Donald E. Fisher</u>				<u>Ellicott City Md.</u>		<u>Dec 27, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-28-55		Western Star		Ellicott City, Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>Dec. 27, 1955</u>		<u>John B. Loughran, Jr.</u>		<u>F.C. Higinbotham, Ellicott City, Md</u>			
		<u>B. E. L.</u>					

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7

BUREAU V. S.

DEC 30 1955

RECEIVED



12047

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12039

Reg. Dist. 193

No. 74

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Cooksville</u>		<u>Rife</u>		TOWN <u>Cooksville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>MORRIS</u> <u>PORTER</u>				<u>Dec. 29, 1955</u> <u>19</u>			
<b>5. SEX:</b>		<b>6. COLOR OR RACE:</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH:</b>	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Nov. 20, 1875</u>	
<b>9. AGE last birthday:</b>		<b>10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)</b>		<b>11. BIRTHPLACE (State or foreign country):</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>80</u> yrs.		<u>Retired</u>		<u>Illinois</u>		<u>U. S. A.</u>	
<b>13. FATHER'S NAME:</b>				<b>14. MOTHER'S MAIDEN NAME:</b>			
<u>John O. Porter</u>				<u>Melvina Poole</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY No.:</b>		<b>17. INFORMANT &amp; ADDRESS:</b>			
<u>No</u>		<u>None</u>		<u>Iona L. Porter, Cooksville, Md.</u>			

<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>		INTERVAL BETWEEN ONSET AND DEATH	
<p><u>420.1</u></p> <p>Immediate cause (a)..... <u>Coronary Thrombosis</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b)..... <u>Arteriosclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....</p> <p style="text-align: center;">DUE TO</p>			<p><u>15 min.</u></p> <p><u>5 yr.</u></p>

<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>	
<u>None</u>		<u>-</u>	
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>	
<b>21c. (City or town) (County) (State)</b>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	
<b>21f. HOW DID INJURY OCCUR?</b>			

**22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.**

SIGNATURE George E. Burdick CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 12-30-55

M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>1-2-56</u>		<u>Mc. Kenna</u>		<u>Howard Co., Md.</u>	
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>24. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>	
<u>Dec. 31, 1955</u>		<u>E. Pearl Mucier</u>		<u>Arthur A. Wright - Sykesville, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1961

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

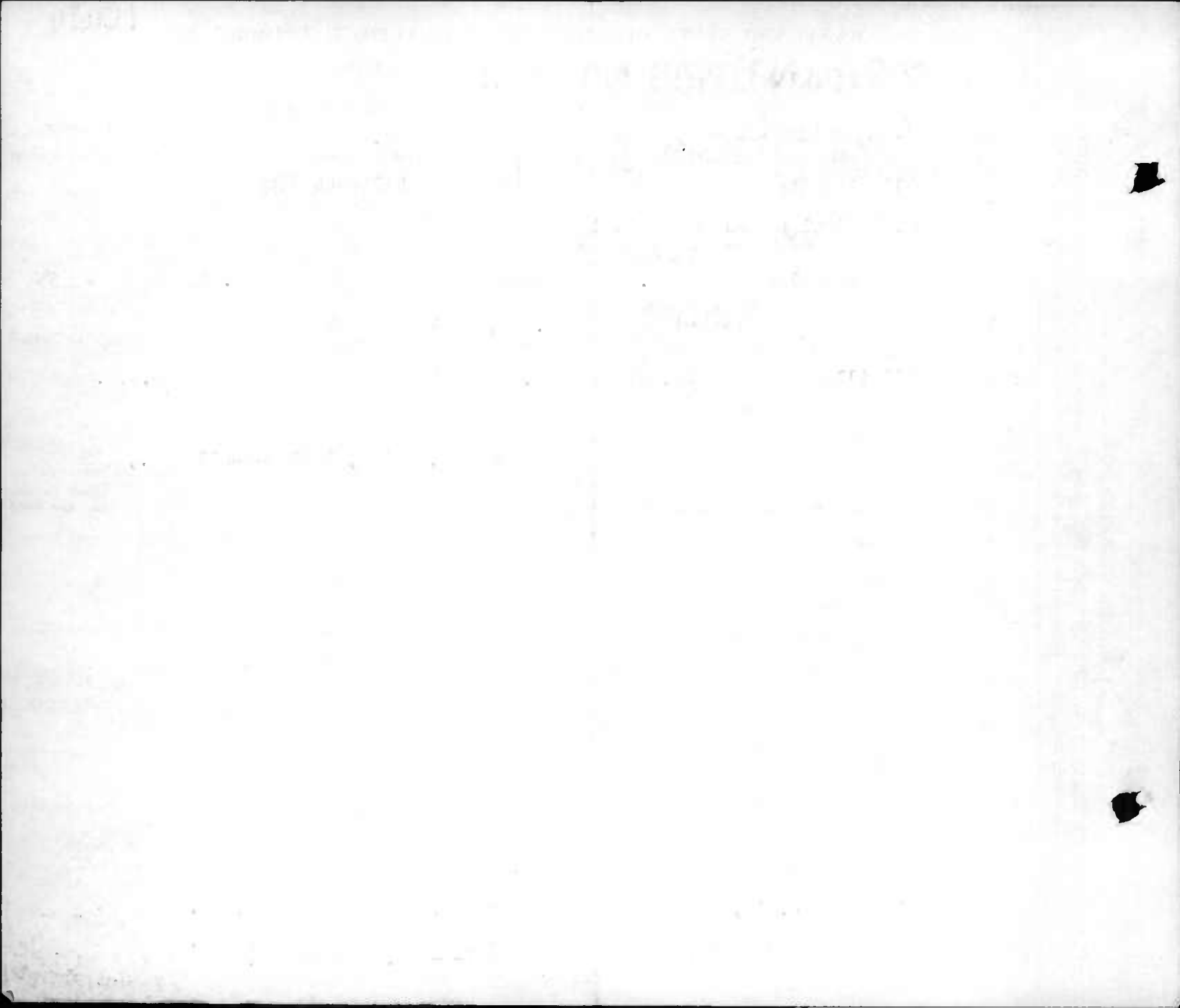
12040

12048

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Howard</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Howard</i>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL		CITY (If outside corporate limits, write OR and give nearest town)		RURAL and give nearest town)	
X TOWN <i>Ellicott City</i>		(in this place)		TOWN <i>Ellicott City</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Highland Manor Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <i>Nicholas</i>		(Middle) <i>L.</i>		(Last) <i>Smith</i>		(Month) (Day) (Year)	
(Type or Print)						<i>Dec. 15 19 55</i>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<i>male</i>		<i>white</i>		<i>widow</i>		<i>Aug. 13, 1874</i>	
9. AGE last birthday:		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>81</i> yrs.		<i>Beth. Steel Corp.</i>		<i>Kentucky</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Unknown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.:			
<i>no</i>							
17. INFORMANT & ADDRESS:							
<i>George E. Smith, 1901 Maxwell Ave., #22</i>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Interval Between Onset And Death							
Immediate cause (a) <i>Chronic Pyelonephritis</i>							
Antecedent causes (s) (b) <i>DUE TO</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>DUE TO</i>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <i>Generalized Atherosclerosis</i>							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)							
PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)							
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <i>11/13, 1958</i> , to <i>12/15, 1958</i> , that I last saw the deceased alive on <i>12/14, 1958</i> , and that death occurred at <i>5226 Balt. Nat. Pike</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm. J. Miller M.D.</i> ADDRESS <i>12/17/58</i>							
23. BURIAL, CREMATION, REMOVAL (Specify)							
DATE THEREOF <i>Dec. 19, 1955</i> NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i> LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>							
DATE REC'D BY LOCAL REGISTRAR: REGISTRAR'S SIGNATURE <i>Wm. J. Miller</i> 24. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> ADDRESS <i>2601-3-5 E. Madison St.</i>							



## CERTIFICATE OF DEATH

Reg. Dist. No. 195

12049

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town</u>		LENGTH OF STAY (in this place) <u>50 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		OR TOWN <u>Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore Street</u>				STREET ADDRESS (If rural give location) <u>Baltimore Street</u>			
3. NAME OF DECEASED: (Type or Print) <u>Maudie L. Specht</u>				4. DATE OF DEATH: (Month) <u>Dec</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed June 30, 1891</u>		8. DATE OF BIRTH: <u>64 yrs.</u>	
10a. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Marshall Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Walter J. Redmond</u>				14. MOTHER'S MAIDEN NAME: <u>Rose Otterback</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>If no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>?</u>		17. INFORMANT & ADDRESS: <u>Carl C. Malone, Syattsville, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause <u>153X Abdominal Carcinomatosis</u>				<u>3 mos.</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <u>Carcinoma of Bowel</u>				<u>2 yrs.</u>			
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>1 Sept. 53</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Bowel</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1st</u> , 19 <u>55</u> , to <u>Dec 9th</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/8/55</u> , and that death occurred at <u>4:30 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank Shipley, M.D.</u>				DATE SIGNED <u>12/9/53</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 10, 1955</u>		<u>Savage Cemetery</u>		<u>Savage, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/9/53</u>		<u>Frank Shipley</u>		<u>Dr. W. H. Donaldson, Larchmont, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1935

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12042

12059

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>AA Co</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Ellicott City</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Dorsey</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Schaffer Conv. Retreat</b>		STREET ADDRESS <b>Ohio Ave.</b> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>Lillie M. Spencer</b>	(First) (Middle) (Last)	4. DATE OF DEATH <b>Dec. 31, 1955</b>	(Month) (Day) (Year)
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>M</b>	8. DATE OF BIRTH <b>May 29, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE last birthday <b>70</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Lisbon Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Joseph Eyler</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY No. <b>NO</b>	
17. INFORMANT <b>Albert W. Spencer - Husband</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>174X Immediate cause (a) Carcinoma of Uterus</b> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>16/21/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Uterus</b>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>HOMICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 1st, 1955</b> to <b>Dec 31st, 1955</b> , that I last saw the deceased alive on <b>Dec 31st, 1955</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Frank E. Shipley, M.D., Savage, Md.</b>		DATE SIGNED <b>1/1/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>1/5/56</b>	NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>	LOCATION (City, town, or county) (State) <b>Gambers Carroll Md.</b>
DATE REC'D BY LOCAL REG. <b>1-2-56</b>	REGISTRAR'S SIGNATURE <b>John T. Stansbury</b>	24. FUNERAL DIRECTOR ADDRESS <b>John T. Stansbury 6411 Windsor Mill Road 7</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 4 1956

BUREAU V. S.

Frank E. Dwyer  
deputy

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

12043

12051

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Whiskey Bottom + All Saints Rd</u> LENGTH OF STAY (in this place) <u>15 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel (Charles)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel, Rural</u>		STREET ADDRESS (If rural, give location) <u>Whiskey Bottom + All Saints Rd</u>	
3. NAME OF DECEASED (First) <u>Monarda</u> (Middle) <u>Le Boeuf</u> (Last) <u>Walker</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 18, 1873</u> (82) <u>82</u> yrs.
9. AGE last birthday		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Quebec, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Marcel Le Boeuf</u>		14. MOTHER'S MAIDEN NAME <u>Edwidge de Bress</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Marie-Anne Salpe (above)</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
431X Immediate cause (a) <u>Acute Myocarditis</u>			<u>2 mrs.</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>December</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>55</u> , and that death occurred at <u>7:35 A.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert S. McConney Jr.</u>		ADDRESS <u>462 Mann St Laurel Md</u> DATE SIGNED <u>12/12/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>Dec 14, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u> LOCATION (City, town, or county) <u>Laurel, Maryland</u> (State)
DATE REC'D BY LOCAL REG <u>12/13/55</u>		REGISTRAR'S SIGNATURE <u>Frank Shipley</u> 24. FUNERAL DIRECTOR <u>St. With Cathedral, Laurel, Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 21 1955

RECEIVED

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

12052

Reg. Dist. No. 19.1

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ellicott City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Columbia Road</u>		STREET ADDRESS (If rural, give location) <u>Daniels Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>SUSIE</u>	(Middle) <u>G</u>	(Last) <u>WEBB</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	4. DATE OF DEATH <u>Dec. 31, 1955</u>
8. DATE OF BIRTH <u>Sept. 7, 1888</u>	9. AGE last birthday <u>67</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
11. BIRTHPLACE (State or foreign country) <u>London County Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Webb</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Riley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>217-05-4956</u>	
17. INFORMANT AND ADDRESS <u>Mary Webb, Ellicott City, Md.</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>acute cardiac failure</u>		<u>Immediate</u>
(b) <u>arteriosclerotic heart disease</u>		<u>10 years</u>
(c) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-4-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	LOCATION (City, town, or county) <u>Ellicott City, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 3, 1956</u>	REGISTRAR'S SIGNATURE <u>John B. Loughman</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md.</u>	

BUREAU V. S.

JAN 9 1900

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